If continuation sheet 1 of 1

Division	of Health Care Fac				PRINTE FORM	APPRO	
AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	Torri	. 01 100 00	
		SECTIFICATION NUMBER:	A. BUILDING: 01 - MAIN BUILDING 01		COM	(X3) DATE SURVEY COMPLETED	
			1		ļ.	_ -	
		TN5404	B. WING		أ		
NAME OF PROVIDER OR SUPPLIER STREET A		DDRESS, CITY, STATE, ZIP CODE			11/12/2015		
AHC HE	ALTHCARE, ATHENS	1204 FR	YE ST	MATE, ZIP CODE			
		ATHENS	, TN 37303				
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			
TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	LEAUH CORRECTIVE ACTION	2U/VIII D 2~	(X5) COMPLE	
			TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
N 002	1200-8-6 No Defici	encies	 	DEL TOICHET)			
	110 201101	Choles	N 002				
]]				
1	December 11 1 1 2 2		1				
	During the Life Safe	ety portion of the annual					
	modified ant AGA CU	NOLICTOR ON 11/10/45			i		
	denciencies were ci Standards for Nursi	Ited Under 1200.0g og	1		ĺ		
		ny nomes,	1				
			1				
			1				
			ł /		!		
					İ		
]				
		,					
			.				
			1		1		
			1				
		ľ	ĺ				
		1					
		f			ļ		
		1	1				
		1	1		ļ		
		ļ	ŀ		İ		
		,	ļ		İ		
	•	į					
		,	ļ				
		j					
1		Í					
		Ì	ŀ				
			1				
of Linetth	0						
or riealth TORY∕DIRI	Care Facilities	SUPPLIER REPRESENTATIVE'S SIGNAT					
H-P"	1	PUPPLIER REPRESENTATIVE'S SIGNAT	URE	TITLE	(X6) I	DATE	
FORM	M Stan			Administrator		5/15	
7, ""	1	6899	THRMS	TI WINIS / INTO	11/8	5/15	

THBN21